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ABSTRACT

A case study is presented which seeks to understand the provision of health services to university students, specifically in situations that require an integration of treatment. The relationship of the effects of traditional bureaucratic structures on quality of services provided for students is explored by looking at the relationship between organizational structure, individual practitioner ideas, and the larger societal context in the provision of health care services for students with eating disorders. The complex nature of eating disorders requires treatment from a variety of sources including medical, psychological, dental, nutritional, and fitness assistance; these services need to be integrated. The positioning of health services under student affairs is discussed. In the study, semistructured interviews were conducted with six staff members involved in the treatment of eating disorders. Data were coded and a matrix of typologies was developed. Findings are presented and discussed in terms of "tensions between organizational structure and the goals of treatment," "the development of strategies to overcome limitations," and "the importance of motivated individuals." This case study serves as an example of how organizational factors can paralyze otherwise intelligent and motivated individuals and prevent them from working toward their goals. (EMK)

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# Hindering Health? The Influence of Health Service Organization on the Delivery of Care for Eating Disorders in a University Setting

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## Introduction

Many recent criticisms of university functioning have focused on problems with the bureaucratic structure arguing that it hinders change and innovation (cf. Benjamin, Carroll, Jacobi, Krop & Shires, 1993; Wilms, Teruya, & Walpole, 1997). The bureaucratic, hierarchical model of organization dominates at the majority of today's colleges, including their divisions of student affairs. This organization by units rather than processes, a structure commonly referred to as "silos," is known to encourage insularity within departments and prevent communication and innovation across areas (Morgan, 1997). Interestingly, little of the research conducted on organizational structure in universities has looked at the outcomes for students. If the structure hinders effective work, how does that effect the quality of services provided for the students. The goal of this study was to explore this question by looking at the relationship between organizational structure, individual practitioner ideas, and the larger societal context in the provision of health care services for students, specifically services for students with eating disorders.

For many undergraduate (and graduate) students the only medical care they receive is that provided by their college or university student health system. A survey conducted in 1987 for the *Journal of the American Medical Association*, found that 10 million students are served annually in college health services (Christmas, 1995). Thus it is important that we understand how these services are being provided and what may impinge upon their success. As Jackson and Weinstein (1997) assert, "the creation of healthy university communities is essential to the intellectual, social, and emotional development of America's college students." (p.240). Yet, many factors can prevent colleges from attaining integrated and successful services, including organizational structure, a lack of funding, and changing student demographics (Christmas, 1995; DeArmond, 1995; Thier & Keohane, 1998).

Treatment for eating disorders often involves combining many disciplinary perspectives. Understanding this approach can be useful in understanding and treating many other problems facing today's college students such as HIV/AIDS, other sexually transmitted diseases, depression, and pregnancy, as well as drug and alcohol abuse. De Armond (1995) suggests that many of these problems extend far beyond the need for simple biomedical interventions, and require the work of interdisciplinary teams to focus on the behavioral, social, and psychological aspects of these concerns. This study will examine the provision of this type of treatment within a university health care unit.

## Background

### Treatment of Eating Disorders

Estimates of the percentage of college women who suffer from eating disorders range from about 1% to 10% (Kurtzman et al., 1989). Although these percentages may seem small, when one considers that approximately 7,900,000 women were enrolled as undergraduate students in the United States in 1994 the actual number of these female students estimated to suffer from eating disorders would be 79,000 to 790,000 (National Center for Education Statistics, 1996). Like any mental or physical health problem, eating disorders can disrupt the normal life functioning of a college student. Psychological distress, illness, obsessive exercise, and ritualistic eating, restricting, or purging behaviors all take time away from the usual processes of academic life such as studying and socializing.

In the *Guidelines for the Outpatient Management of Individuals with Eating Disorders in the University Setting*, Hotelling and Liston (n.d.) outline an exemplar of an interdisciplinary approach to the treatment of eating

disorders. The complex nature of the disorder requires that those afflicted receive treatment from a variety of sources including medical, psychological, and dental care, as well as nutritional and fitness assistance. The authors of this document, who represent a number of these disciplines, suggest that in addition to being multidisciplinary, services need to be integrated. The program of treatment outlined in their document requires constant communication among the health care providers. Monthly meetings with all individuals involved (often including the support staff who referred the individual), are conducted to ensure that the student is receiving adequate and appropriate treatment.

Organization of College Health

Historically student health services on university campuses were organized to help control the spread of epidemics. Thus, the focus of care in colleges, similar to that in the medical profession in general, was on the treatment of disease (Christmas, 1995; Jackson & Weinstein, 1997; Leafgren & Elsenrath, 1986). More recently, health care professionals and the general public have come to realize the importance of a broader, more person-centered focus on health, a focus on preventative care and the encouragement of healthy lifestyles.

Jackson and his colleagues (1997) note that health services have generally been encompassed in student services because of several assumptions: " (1) student development enhances learning and (2) personal circumstances and the out-of-class environment affect the learning process." (p. 237). Leafgren and Elsenrath (1986) note that the current wellness approach prevalent in health care is very consistent with the values of student services. The orientation toward the whole patient that is so important in wellness mirrors the focus of student services on the maximization of functioning for the whole student.

College health services are generally funded primarily through tuition and general funds (Christmas, 1995). Unfortunately, changes in the appropriations for higher education in recent years and the ensuing tightened budgets have served to constrain the amount of funds made available for health services in many colleges (DeArmond, 1995). Some suggest that services like health care are at greater risk for cuts because like many student services they are considered by many to be ancillary to the core processes of the university (DeArmond, 1995).

Several common themes can be found in the discussion of how college health services should be organized and the factors that may impinge on effectiveness. In terms of optimal organizational functioning, many authors stress the importance of integrated, multidisciplinary, and "seamless" care (Christmas, 1995; DeArmond, 1995; Patrick et al., 1997). Another focus is on the provision of "total person" health care, or a wellness approach (Christmas, 1995; DeArmond, 1995; Jackson & Weinstein, 1997; Leafgren & Elsenrath, 1986).

Among their recommendations for how to improve the provision of college health services, Patrick and his colleagues (1997) identified the importance of using new models and perspectives in studying effectiveness. They suggest that individuals studying college health should utilize alternative models and perspectives, such as those from anthropology and sociology to expand understanding of the system. These disciplines can help by expanding the focus of inquiry beyond a traditional biomedical focus on the individual and his or her pathology to a wider view of the college health context. Research in this area needs to begin to recognize that a disease does not exist separate from the individual, and the individual does not exist separate from the cultural context of the health care system.

## Purpose

The purpose of this study is to understand the provision of health services to university students, specifically in situations that require an integration of treatment. In order to attain this end, the following grand tour question is posed:

- What influences how student health services are delivered in a university setting?

Several sub-questions emerge to further guide the research:

- What personality and background characteristics do providers and patients bring to care and what influence do they have on how the care progresses?
- What influence do organizational factors have on the delivery of services?
- What influence do larger social, cultural, and economic contexts have on the delivery of services?
- How do all of these factors combine in the construction, or definition of "the problem" facing the student, and guide the treatment approach?

## Theoretical Framework

Kleinman (1980) provides a useful framework for a study of this kind. He notes the importance of a focus on the whole person in the context of treatment. Kleinman states that within a society, health behaviors are interrelated and thus must be studied in a holistic manner. He outlines an overall "health care system" in which individuals function.

> [The health care system is] a cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions...the health care system, like other cultural systems, integrates the health-related components of society. These include patterns of belief about the causes of illness, norms governing choice and evaluation of treatment, socially-legitimated statuses, roles, power relationships, interaction settings, and institutions. (p.24)

He notes that patients and healers are critical basic components of this system, and in order to truly understand them we must study them in their cultural environments. The cultural context of the treatment situation, the shared system of symbolic meaning that makes up the health care system, will influence, among other things, choices that are made, how people relate, how individuals view treatment alternatives, and how individuals feel about the choices (or lack of them) that are available.

Kleinman recognizes that health care systems must be understood as local social systems that vary by setting. He also recognizes them as social constructions, not entities in and of themselves. He emphasizes the importance of the actors in a situation in constructing the meaning and structure of that situation. Finally, he also asserts the importance of studying the health care system itself in the larger societal context; political, economic, social structural, historical, and environmental influences all help to shape health care beliefs and activities.

## Methodology

This study employed a qualitative case study framework to understand the cultural context of treatment in a student health organization (Marshall & Rossman, 1995). In depth interviews were conducted with the staff involved in the treatment of eating disorders. The interviews were semi-structured, with some basic, broad introductory

questions to introduce the topic. Further questioning was based on the responses of the informants. The initial questions served simply as a guide for interviews; the questions were not asked directly if they were touched on in other responses, or if they seemed irrelevant in the light of other information provided. This procedure allowed the informants to define what is important about the treatment context based on how they perceive and construct meaning in it.

Subjects

The study utilized 6 informants. Among these individuals was at least one representative from each of the following areas: nutritional, medical, and psychological care. Informants were identified through their positions on the staff of the university health services, and then recruited to participate through phone calls and e-mail.

Although student informants were part of the intended study, no volunteers came forward. Future studies of this type will have to consider additional recruitment options and methods of subject identification. Student voices are critically important in the sense that they will tell us whether the things we posit as being necessary for better care are in fact those things that students think will help them. Consistent with Kleinman's (1980) recommendations, all of the actors involved in the health care system must be considered for the entire picture to emerge.

Procedure

The interviews lasted between 45 to 60 minutes. All but one of the informants agreed to be tape recorded, handwritten notes were taken with the remaining informant. The basic interview questions were as follows:

- Please describe the process you go through in working with a student with an eating disorder (possibly follow a hypothetical student through the process)
- Are there particular aspects of your experience that lead you to approach the treatment of eating disorders in this way?
- Have there been any experiences that have changed your perspective on care? What were they? How did they change you?
- Is working with students in SHS/SPS different than treating individuals with eating disorders in other situations in which you have worked? How so?
- What type of contact do you have with other individuals involved in a particular student's treatment?
- Are there any aspects of the program of treatment at SHS/SPS that you think might be important to someone trying to understand the dynamics of these services?
- Do you have any questions for me?

Data Analysis

After each interview the tape was transcribed. After transcription was completed, preliminary open coding was used to develop themes based on overall impressions of the data, what Marshall and Rossman (1995) call category generation. As focused coding progressed, coding categories were changed, expanded, collapsed, and divided based on the subtleties and nuances of the data. During this period, in accord with the suggestion of Marshall and Rossman, a matrix was developed to organize the typologies. This matrix also served to illustrate how the initial interview questions and study objectives had served to shape the data, as themes generally fell into the three categories of personal, organizational and larger societal influences, along with the conflict between them. After final

coding categories were established, the transcripts were reviewed based on the final codes to be sure that all sections were coded correctly based on the final schemata.

Although this study did not seek specifically to utilize narrative analysis, some aspects of this methodology were useful to me in guiding the focus of data analysis. Under this method, it is important to attend to the construction of meaning and interpretation on multiple levels. Riessman (1993) outlines the levels of representation in the research process: attending, telling, transcribing, analyzing, and reading. She notes that at each level of this process there is interpretation, either by the informant, the researcher, or the final reader of the product. Interpreters of narratives must then be aware of these levels of interpretation and be critical and reflexive in determining what they mean for the final "co-constructed" narrative. This focus helped to shed light on why individuals might be telling the stories they did, what was articulated and what avoided. The interview context encouraged these individuals to reflect critically on their current work environment, a fact which may have caused discomfort and limited participants' willingness to be completely open. Attention to the larger context of the storytelling allowed me to identify cues to how information was being managed by the informants. The content of the interviews was then examined and interpreted in this light.

## Site Description and Context

Before delving into the substance of the findings from this analysis, it is important to describe the basic setting, organizational structure, and societal context in which the study is embedded. The study was conducted at a large research university on the west coast, with well established student health and counseling services. Both the student health service and the student psychological services are encompassed under the umbrella of the university's student services division. Although both units are part of student services, they maintain separate facilities, as well as separate directors and clinical staff. The university does maintain a large medical center and medical school, but these units function outside of the student services sector.

With regards to the treatment of eating disorders, a student can enter the system through either the health or the counseling unit. No formal system exists for ensuring that a student with an eating disorder is seen at both units. Generally, students are encouraged to see medical, nutritional (a sub-unit of the health service), and psychological providers, but each student can choose whether or not she wants to be seen by any or all of the various providers. In general, visits with providers in the medical unit are scheduled in 20-30 minute increments (however nutritional visits often offer more flexibility of time), while visits with providers in the psychological services are in 50-minute increments. Students can visit the medical services an unlimited number of times, while psychological services are generally limited to short-term intervention that can be done in 6-9 visits.

Although unknown to me at the time I was planning my study, a critical event occurred just prior to my interviews that provided a unique context for my study, and I believe brought into more sharp focus the types of issues I was interested in exploring. Several months prior to my interviews, the staff nutritionist resigned, specifically because of her discontent with organizational limitations on her ability to do her job as she felt necessary with regards to eating disordered clients. Her absence, and the concerns she raised prior to leaving brought the particular context in which I was interested closer to the front of many of these practitioners' minds. I believe that this made many of the concerns easier to articulate for these informants. In addition, my access to the nutritionist after her departure

allowed me to gain additional perspective on issues surrounding care from someone who was presumably less constrained by the idea of reflecting on her employers than those individuals currently working. However, different contextual cues, such as those of possible animosity were attended to in analysis.

Another important context is the current societal context with regards to medical care. We are at a point in history when it is accepted and often encouraged that we reflect critically on medicine and on the third party payers such as HMOs which people feel are further limiting effectiveness. This climate may both make individuals feel more comfortable with expressing dissatisfaction and also provide them with a readily accessible "language" with which to speak about it.

## Findings

In referring back to the original levels of analysis proposed earlier as sub-questions, focus is inevitably drawn to the final question: how do all of these factors (personality and background of the provider, organizational structure, and societal context) combine in the construction, or definition of "the problem" facing the student, and guide the treatment approach? This final question is really the substantive question for this study, while the others just serve to frame the individual components. Like any complex system, those components do not operate independently but rather interact. It is in the interstices or "borderlands" where they interact, and in this case where there is conflict, that the interesting story lies.

Although many interesting themes were identified in this study, I have chosen to focus on the organizational level and its interactions and conflicts with the personal goals and ideas of practitioners, examining what constraints these conflicts place on the provision of care. Specifically, the themes of 1) tensions between the organizational structure and the goals of treatment, 2) the belief among providers that administration supports integration and depth of service in theory but not in practice, and 3) the development of strategies by providers to work around conflicts, and the limitations imposed on this process, will be considered. These three broad themes combine to tell a story of how organizational structure can limit effectiveness and lead to feelings of frustration and disempowerment among those involved.

### Tensions Between Organizational Structure and the Goals of Treatment

Among the providers of care there was unanimous acknowledgment of the importance of several key treatment goals including: providing a multidisciplinary treatment approach, providing long-term care and follow-up, and a focus on the whole individual in treatment. They talked of their desires for treatment teams and partnerships, as well as open and frequent communication. As one provider put it,

> I am looking at being part of a team that treats these patients and I am not anticipating that I am giving them their total care. A lot of what I do depends upon the other members of the team, which my team should be a mental health provider, a nutritionist, and um sometimes there may be other people on that team depending upon whether they have other needs.

The providers talked about the complex nature of the disorder, which necessitates approaching it from multiple angles and having some way of combining those perspectives into an integrated treatment plan for the individual patient.

It was clear from these interviews that one component of such a multidisciplinary approach was the need for frequent communication, the multiple disciplines could not each work independently with the student and obtain the

same result. However, organizational factors such as scheduling kept these practitioners from meeting on a regular basis.

> For a while we were doing a case conference, but we haven't done that for a while just because staff changes and just irregularity in people's schedules, but it was sometimes useful. Sort of depending on who actually attended the meetings. It was sporadic. It is just hard to fit schedules, and there are so few opportunities to get on the books a time where all of our [staff can] get together for a treatment meeting.

One provider questioned how other universities were able to have meetings of even larger groups while at her university getting even a few people together was problematic, with individuals constantly being called off to other things.

> It was really very difficult to get people together, trying to schedule the meeting for everyone to show up. That's why when I saw the Southern Illinois University thing and all the people that are on their eating disorder treatment team, I thought *what*, how do they get these people together. Because, frequently it would just be Dr. ____ and myself showing up, and you know then Dr. ____ would be pulled off to clinic.

Although the desire for more frequent and formalized communication mechanisms was desired by all involved, and attempts were made to enact them, the reality of these meetings was rarely, if ever, achieved at the desired level. At this institution the providers appeared not to be in a great deal of control over their own schedules. The providers seemed to feel that the administration demanded that clinic time (individual visits with patients) take precedence over all other aspects and that they were not free to alter that schedule.

In terms of the desire to consider the whole patient who appeared for treatment, a key element in providing comprehensive care, one of the first considerations was the length of time available for the consultation. One provider noted that it was virtually impossible to even do a complete history in the time allowed, let alone establish a level of trust with the patient. Many providers noted that an important component of treatment was dealing with the nervousness and discomfort that often prevented students with eating disorders from opening up in the clinical setting. They lamented that this process of establishing rapport took much more time than they were allocated for each visit, especially in the medical unit.

> I would like to see these visits be at least an hour long, um so that I have time to really do a good in-depth history and so the person can get comfortable, and then to be able to follow up people at least once a week if not more than that. If people identify themselves as an eating disorder, they'll give me half an hour, but many times people will say fatigue, or personal problem or something, and I get twenty minutes, and by the time I come in and say hello (laughs) and that doesn't count the by the ways, with the by the way's I get two minutes.

Some practitioners noted that beyond the "by the ways," some eating disorders may even go unidentified because short visit times prevent the providers from exploring these issues with students who may come in listing other complaints.

Another way in which practitioners believed services could be more effective was in increasing the length of time (total number of visits) for which students could receive treatment. This of course was more of an issue with psychological services, where limits on the number of visits were imposed (in contrast with the concern with time per visit found in the medical services). However, it was a concern for both units when looking at periods such as

summer break when students might not be covered if they were not enrolled in summer courses. Providers noted that eating disorders are considered chronic, ongoing conditions and thus need a program of treatment that extends over a long period, perhaps even requiring treatment over all the years that a student is in attendance at the institution. The only other options for those students who need extended care are the services associated with the university's medical center (or another private provider) which are highly costly, or to seek public services outside the university in the county's rapidly eroding and under-funded health care system.

Beyond the limitations posed by length of visit and length of treatment already discussed, providers also identified the limited daily hours of services as problematic.

> Once someone gets to college I think the major problem I see is that the health care services in general are 8-5 services and those hours do not fit for students who are usually in class during that time period. I think that there are institutional barriers that have not been broken down, and I think it really is a struggle with an eating disorder. They really do need to have more available care, rather than going 8-5, and they are going to have to make a long term commitment to care, so it is hard to fit that with a class schedule.

Among the suggestions made for alternatives were offering night treatment options, such as evening group sessions, or even an on call position that would provide patients with someone to consult and talk with at any hour of the day.

The providers' focus on the whole person led them to suggest the inclusion of additional components to the treatment process beyond the medical, psychological, and nutritional care. Among them were fitness services, programs with food service (both on the general campus and in residential life) to provide nutrition information and healthier alternatives, and skill building activities such as stress management workshops, and self esteem and body image programs. Although many of these programs have existed individually on the campus at different times over the years, efforts to integrate them into a long-lasting program have been unsuccessful, a point which will be explored in more depth in later sections.

The separate physical locations pose an additional constraint as, among other things, this limits the possibility of spontaneous, informal interactions in the hallways that in other situations might lead into more regular or formalized consults. In addition, the separate locations make it more difficult for providers to encourage students to seek out care at the other unit. Some providers noted that if they walked a student over they were more likely to at least make an appointment--a process that could be made easier and more frequent with contiguous locations. Providers speculated that with more integrated service and closer follow-up, fewer students would drop out of the system than is now the case. However, one provider suggested that as long as the psychological and medical services are different units, the ideal of integrated treatment will never happen.

This is not to say that only organizational factors come into play in limiting the implementation of more integrative and in-depth services. Some degree of personal interest and involvement also enters into the picture. For example, some providers mentioned that it would be difficult for them to do other than work within the 8-5 framework because of other obligations such as family and private life. Though they felt that these services would be important, they appeared unsure as to whether they themselves would be willing to provide them if the opportunity were to arise.

The providers also recognized the influence of economics in the feasibility of a major overhaul, and how economic constraints might play into smaller scale ideas as well. Changes to any of these structural problems--

increasing the length of visits, number of appointments available, number of hours services are available, or the number of sessions for which an individual could be seen--all come down to an economic reality. The cost of providing care would increase because most would require an increase in staff and/or facilities.

Perceived Level of Administrative Support

The previous section primarily detailed conflicts with organizational structure, however the providers identified another element to the organization that led to constraints on the services provided--the priorities and actions of the individuals involved in administering the organization. Much of the discussion of administration centered around the setting of priorities. Providers felt that administrative priorities were not in line with their own and this caused them concern.

In discussing why much needed task-forces or committees were disbanded, one provider cited shifting administrative priorities as a major reason for the disintegration.

> I don't think it is because people change. Because the same people are here, who were on the task force, I think that the administrative priorities probably changed. And I think that instead of doing a lot of outreach and programming, at this point in time I think that everybody is just trying to get their job done...I also think it is a time in health care when there is a lot of cut backs, from anything more than just seeing the patients, so I think it may be more of a factor of changing priorities of administration rather than the staff and I think that its not just from Student Health, but in other areas of the university are feeling the pressure of numbers and costs and there has been years of nothing but budget cuts and now that the budget is a bit more stable maybe they'll start thinking about outreach again... but I think that the people who were on the task force were very interested in and willing to keep doing it, and felt it was important to do.

This discussion touches on a concern that many providers expressed--that administrative priorities are much more influenced by market forces and business ideologies than the goals and values of health care.

Providers were quick to point out what impact this purely economic focus has on the quality of care and the way that individuals perceive what it is possible for them to do.

> I think what you have here is you have systems, and people, and individuals who have the knowledge, the experience, and the desire to work, and you have structures that aren't supporting that work, you know I tell you the wellness task force was disbanded, as far as I know is not in operation, our eating disorders task force was disbanded. Um, I think you have a different organizational priority that has shifted...This is not a priority for them at all, at all, not worth putting the resources in, and I don't know what it would take. I think too that we see a very, very small percentage of the people with eating disorders. You'll find that frankly some of my students who are doing the best are getting outside care, they have private insurance and are able to get care outside the university.

This provider was not the only one to suggest that students who were able to obtain private care were more successful in managing their disorder.

After a lengthy interchange with me about who would have access to my transcripts and subsequent report, one provider had this to say about the level of administrative support one might hope to receive for a proposed project.

> I will say this, I think that the administration has been supportive of outreach efforts, um but with the demands...there is so many demands really on administrations time that this has not been addressed specifically...I have made recommendations, it is a project that I certainly have in mind to do, but if I do it I would have to do it on my own. In other words it would be something that I would develop, organize, and then I would go to administration, and probably I expect that they would be supportive, but I don't think at this stage that they have the time or the resources or the staff to be able to, to actively support an effort. I think I would get certainly approval...but again I would have to organize it, um set it up, make the presentation, and do it on my own time.

The underlying theme in this passage echoes the refrain found in the reports of other providers. Although for many of them a detailed conceptual plan exists in their mind, organizational factors (combined with some personal constraints) prevent this plan from being executed; these individuals feel disempowered. As noted above, some even seemed reluctant to discuss their feelings openly in the interviews for fear that it would get back to the administration.

Although these providers paint a very grim picture of the level of administrative support for efforts to integrate and extend care, there were cases in which they found themselves at least partially supported. For example, within the psychological services, providers did note that there was some administrative support for "case management," and following-up chronic cases like eating disorders on a monthly basis. Thus there does appear to be some support for small scale, low cost strategies, but substantive support for a large-scale effort was lacking.

The problem does not appear to be one of making desires known to administration, as many providers mentioned that they had made frequent suggestions regarding these matters. Instead, it appears that despite the widespread interest, administrative priorities have sent the message that these changes will not be considered. At this point, however, it is important to note that one of the limitations of this study is the fact that individuals at the administrative level were not interviewed. It is possible that the sense that administrators may have significant control over how these processes play out gained from these interviews may be overstated because the administrators represent the conflictual "other" to many of these practitioners, making it easier for the providers to place responsibility for outcomes with administration rather than themselves or other practitioners[1].

Development of Strategies to Overcome the Limitations

In the face of all of these problems, the providers have found ways to accomplish some of their goals. The six providers interviewed maintained an active informal network; each provider could name the other five individuals actively involved in this care,[2] and discussed referring patients to them and trying to maintain at least some one-on-one communication with those individuals in the absence of group meetings. One provider gave a historical perspective on the ebb and flow of formal and informal communication strategies.

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[1] Interviewing administrators was considered for this study after preliminary findings suggested interesting conflicts, but due to the constraints of the human subjects protection process, their participation would have been almost useless. These subjects would have been almost immediately identifiable if labeled as administrators, thus there was no way to set up a distinction between the different levels of the organization without violating the guidelines agreed upon by the researcher.

> It has changed over time as our personnel changes, and as priorities change. We started back in the 80s with the nutritionist from student health and one of the psychologists, and we sort of had an informal team, you know we realized then that we needed each other to help learn and treat these patients and then over time it has evolved to where we did have a multidisciplinary team from student psych and student health that was called the eating disorders task force, and we actually met on a regular basis and presented cases...but the uh nutritionist resigned, and has not been replaced...[and] there has been no impetus...nobody else has come forward to reform the task force, so basically now we are just trying to provide some care, and try to communicate back and forth.

One of the underlying themes that emerges here is the importance of particular individuals (in this case the nutritionist) with the drive and interest to sustain an effort in the face of challenges, a factor that will be explored in greater depth in the next section.

The providers also turned to forms of written communication to convey important case information when they were unable to meet face to face.

> That's what we tried to do within the eating disorder team was to try to specify who was going to be looking out for what...so we had this form, the multi-disciplinary eating disorder, it was the eating disorder treatment team form...and it goes through um the um, the clinical, social, medical, you know, drug problems, vomiting, purging...you know, that kind of thing, and so whoever saw that person first could fill out as much information in it as possible, it would go in the chart and then the next clinician who was getting the referral would fill out other stuff and would at least know...So that was the way we started to try and communicate.

Developed during a time when the group was meeting successfully, this paper trail survived where in-person communication was not able to. Though limited in its overall usefulness to providing factual information and not allowing for the discussion of treatment options and the hashing out of disagreements, this form at least served to keep providers up to speed on what each provider was doing. One possible constraint in this process is that the charts for each unit are separate and are thus stored in separate facilities. Thus the form only facilitates communication across units when those providers involved make an effort to obtain the charts from the opposite unit.

One provider mentioned being slightly subversive within the system in order to accomplish what needed to be done. She noted that she was able to "carry" some patients by providing some initial, more intensive therapy and then moving into monthly visits.

> It usually looks though, like six to eight sessions of very intense treatment on a weekly basis and then we sort of drop off to a session every other week, or a session every three weeks, sometimes going out even further than that, so that then they continue to come in, but they are really coming in when they encounter problems.

This model allows follow-up visits to appear as "crisis intervention," a process that fits into the organizational imperatives.

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[2] Interestingly, although not a specific goal of my study, the six providers interviewed turned out to be a fairly exhaustive review of all providers involved in eating disorder treatment on a regular basis.

As one can gather from previous sections, these providers have tried a variety of individual things over the years such as a wellness class, a fitness clinic, and various forms of outreach, many of which have been very successful. Yet no combined, integrated plan has emerged. This does not sound so strange until one considers that when asked, each provider had specific details about possible programs. They obviously have thought about these issues extensively and have a wealth of knowledge and ideas waiting to be tapped. Yet no-one has done it. These providers conveyed a sense that there is a definite need for these services, that it is something that should be done, but the current climate constrains efforts to move forward with this process.

Importance of Motivated Individuals

Many of the above excerpts have alluded to the importance of highly motivated and interested individuals capable of sustaining an effort. In this case, the nutritionist played a critical role in the ongoing maintenance of what programs were possible. She was the chair of the eating disorders task-force, and as noted earlier, this group has not met since she left. While this is not to say that the meetings were progressing successfully before she left, or that there is not interest in continuing them, it does appear that the real impetus to meet at all may have disappeared with her departure. It appears that what has ensued is an inability to act upon ideas among the remaining providers, truly an atmosphere of disempowerment.

Each of the providers interviewed mentioned the loss of the nutritionist at some point during their interview and commented on the absence and its effect on the quality of care. The nutritionist was described by one provider as "a very vital part of the team," and her absence was described by many as the loss of a critical part of the picture both in terms of nutritional services, and in terms of personal interest and commitment.

It may be seen by some that a great deal of personal choice is also involved in preventing efforts. To some extent there is personal priority setting involved. These providers do have other interests, time constraints, and obligations that limit the attention they can give to one area. However, these considerations do not give the whole picture. It is true that no one person wants to work alone and devote all of his or her time and effort to individually spearheading an effort. However, even as a collective, where they might be willing to each devote some time, there is a lack of motivation to begin with due to lack of support. It seems likely that given more administrative support, providers might be more willing to devote their personal energy and time to development, but they would need to feel that their sacrifice would actually produce results, as they have devoted time and energy in the past and perceived only limited success.

## Conclusions and Implications

Economics and structural concerns have been a common refrain in this story, just as they are a common refrain in much of the rest of higher education. However, this story sheds light on how priorities set on how money should be allocated and then spent influence what is possible within an organization. It is true that many of the larger programs suggested by my informants would need considerable resources for implementation. However, I believe that even a small economic investment, perhaps parlayed into release time for staff, accompanied by administrative support for developing initiatives would begin to bring power back to practitioners and their knowledge could be applied to the development of economically feasible plans.

This case study serves as an excellent example of how organizational factors can paralyze otherwise intelligent and motivated individuals and prevent them from working toward their goals. The organizational structure has served to make an group that has generally enjoyed a position of relative power in society, medical providers, to feel almost completely powerless. In this situation there needs to be some effort placed on transforming personal interest and knowledge back into the ability to take action, as it is uncertain whether this process will ever emerge on its own.

When we delve into the economic arguments, we must also consider the idea that the development of an eating disorder program might serve to privilege that particular disorder over others with a disproportionate amount of attention and resources. However, many of these programs could be implemented without specific reference to eating disorders, and in fact would certainly be beneficial to a wide range of conditions. Moreover, the integration of services is an important concept to consider for health services in general as the complexities of the problems facing college students increase.

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